Washington State Department of Social & Health Services

REQUEST FOR RECORDS

A. REQUEST FOR RECORDS BY:

NAME LAST	FIRST	MIDDLE	TITLE

ORGANIZATION OR BUSINESS NAME IF APPLICABLE

MAILING ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)	E-MAIL ADDRESS

B. REQUEST FOR RECORDS FROM: (PLEASE CHECK ALL THAT APPLY)

- ☐ Aging and Disability Services Administration
- ☐ Economic Services Administration assistance programs
- ☐ Financial Services Administration
- ☐ Medical Assistance Administration
- ☐ Division of Vocational Rehabilitation
- ☐ Children's Administration
- ☐ Division of Child Support
- ☐ Juvenile Rehabilitation Administration
- ☐ Division of Alcohol and Substance Abuse
- ☐ Mental Health Division including state hospitals
- ☐ Other: _____
- ☐ All parts of the Department of Social and Health Services (DSHS)

C. ☐ REQUEST FOR CLIENT RECORDS OF:

☐ SELF ☐ OTHER	NAME LAST	FIRST	MIDDLE

DATE OF BIRTH	FORMER NAMES

CLIENT IDENTIFICATION NUMBER	OTHER IDENTIFICATION NUMBER	DATES OF SERVICE	LOCATION OF SERVICE

CLIENT RECORDS REQUESTED: Please specify records requested from DSHS programs marked above in Section B:

- ☐ Records on attached list
- ☐ The following records:

- ☐ All client records held by the DSHS programs marked in Section B.
- ☐ All client records held by DSHS for the named person.

List any limitations on records requested (by date, type of record, etc.):

D. ☐ REQUEST FOR OTHER DSHS RECORDS

I request the following DSHS records:

- ☐ Licensing records for the following facility or provider: _____

- ☐ Other records (describe as completely as possible, including by date, type of record, program, etc.):

E. ACCESS TO RECORDS (COMPLETE THIS SECTION FOR ALL REQUESTS)

- ☐ Please mail me copies of the above records. I understand DSHS may charge for copies of its records under WAC 388-01-080.
- ☐ Please contact me to arrange a time for me to inspect records at the following DSHS office: _____

NOTE: You must show proof of authority to obtain confidential records about others. Use Authorization form, DSHS 17-063, if needed to give permission.

REQUESTED BY (SIGNATURE)	DATE SIGNED

SIGNATURE OF WITNESS OR NOTARY VERIFYING IDENTITY IF REQUIRED	PRINTED NAME OF WITNESS OR NOTARY IF REQUIRED

If I am not the person who is the subject of confidential records, I am authorized to access these records because I am the: (attach proof of authority)

☐ Parent of minor ☐ Legal Guardian ☐ Personal representative ☐ Other:

OFFICE USE ONLY

DATE RECEIVED	RECEIVED AT:	DATE ACKNOWLEDGED	☐ ID VERIFIED HOW:	DATE RECORDS PROVIDED